TESTIMONY OF THE
AMERICAN ASSOCIATION FOR GERIATRIC PSYCHIATRY
Before The
Committee on Veterans' Affairs
U. S. House of Representatives
On the Department of Veterans Affairs Long-Term Care Policies
January 28, 2004

Mr. Chairman and members of the Subcommittee, I am Joel Streim, M.D., a practicing geriatric psychiatrist and President of the American Association for Geriatric Psychiatry (AAGP). In addition to my practice and academic appointment at the University of Pennsylvania, I would note that, while I am not speaking on behalf of the Veterans Administration, I do serve as Co-Associate Director for Clinical Programs at the VA Mental Illness Research Education Clinical Center (MIRECC) in Philadelphia.

I thank you for this opportunity to present AAGP's views on the Department of Veterans Affairs (VA) policies affecting the millions of veterans who will need long-term care in the next ten years. AAGP is a professional organization dedicated to promoting the mental health and well being of older Americans and improving the care of those with late-life mental disorders. Our membership consists of approximately 2,000 geriatric psychiatrists as well as other health professionals who focus on the mental health problems faced by senior citizens.

Mr. Chairman, AAGP greatly appreciates the Committee's willingness to hear our comments on the issue of long-term care needs of our nation's veterans and the need for the VA to address those needs. AAGP brings a unique perspective to these issues because our members serve the older adult patient population, many of whom require substantial long-term care for disabling psychiatric and neurological illnesses.Nine million of our nation's 25.5 million veterans are seniors who served in World War II or the Korean War. Veterans of the war in Viet Nam – the post World War II baby boom generation – are on the cusp of joining their ranks as aging adults. More than half a million veterans are 85 years of age or older, and the VA predicts that this oldest group will grow to 1.2 million by 2010. We currently do not have adequate long-term care services for those who need them, and there is great danger that the coming swell in the number of elderly veterans will overwhelm existing services.

Planning for the mental health needs of aging veterans who need long-term care requires consideration of many factors. Among these are:

- the aging of the veteran population, including the longevity of those with mental illness;

- the prevalence of mental illness among veterans served by the VA, and the high concentration of veterans with psychiatric disorders in the current cohort of nursing home residents;

- the complexity of caring for elderly veterans with co-morbidity from concurrent medical and psychiatric disorders, in both institutional and non-institutional settings;

- the limited psychiatric training of most long-term care staff; and,

- the limited availability and access to psychiatrists, psychologists, and other mental health professionals with subspecialty training in geriatrics.

It is also important to understand the nature of the illnesses and disabilities that require long term care, in order to properly identify the circumstances under which non-institutional long-term care will adequately meet a patient's needs, and to define those situations in which institutional care is unavoidable.

Epidemiological studies over the past decade and a half have consistently reported that the prevalence rate of diagnosable psychiatric disorders among residents of community nursing homes is between 80 and 90 percent. We call them nursing homes, but the numbers indicate that these facilities are *de facto* institutions for the care of patients with mental illness. Across studies, approximately two-thirds of patients have dementia due to Alzheimer's or vascular disease, and more than half of these residents have psychosis and/or behavioral disturbances. In many cases, psychiatric and behavioral symptoms of dementia are the reason for nursing home admission. Approximately one-fourth of residents have clinically significant depression.

In a survey of the Philadelphia VA Nursing Home Care Unit, the findings were similar: 86% of residents have a psychiatric diagnosis. A total of 61 percent of residents have cognitive impairment and 31 percent have symptoms of depression. The notable difference is that the prevalence of schizophrenia and substance abuse is higher in the VA nursing home than in most community facilities. Of the 29 percent in the Philadelphia sample who had a lifetime history of alcohol abuse, 9 percent were still drinking during the year prior to their nursing home placement. A VA national nursing home survey in 1994 reported lower rates of cognitive impairment and depression, but found 12 percent of residents with a diagnosis of schizophrenia, and 4 percent with other psychotic disorders. Any model that is used to plan for institutional long term care services must therefore take into account the astonishingly high prevalence of mental illness among those aging veterans who currently reside in nursing homes.

The high prevalence of mental illness in nursing homes defines the need for extensive mental health services in these facilities. Unfortunately, like community nursing facilities, most VA nursing homes are not staffed by psychiatric nurses, and the majority of long-term care nurses and primary care physicians do not have the skills required for proper assessment and management of the psychiatric and behavioral disorders commonly encountered in their work. While a few VA nursing home facilities have access to consultation from geriatric psychiatrists, these subspecialists are in short supply, and the projected number of trainees in geriatrics falls far short of the projected needs. Unfortunately, there is no systematic plan to ensure the provision of mental health

services in long-term care settings by clinicians with appropriate training in geriatrics and psychiatry. We urgently need to develop alternative models for delivery of quality mental health care to aging veterans with long term care needs.

Recognizing the preference of many elderly individuals to remain in the community, AAGP applauds the efforts of the Veterans Health Administration to expand the availability of non-institutional long-term care options. The doubling of the census of veterans who received home-based primary care, contract home health care, and contract adult day health care suggests improved access to these alternatives to nursing home placement. However, it is not clear whether these programs are providing adequate mental health services for these veterans. Similar to nursing homes, staff in these programs often do not have psychiatric expertise, or access to geriatric mental health consultation. Although we could not find any reports describing the mental health needs of recipients of non-institutional long-term care services, we do know that, historically, as many as one-third of all veterans seeking care at VA facilities have received mental health treatment, and research indicates that serious mental illnesses affect at least one-fifth of the veterans who use the VA healthcare system. Based on the much higher rates of mental illness found in nursing home residents, we would expect that the rates are higher in those who receive non-institutional long-term care than in the general veteran patient population. In this context, lack of system-wide plans to provide mental health services to non-institutionalized long-term care recipients is troubling. As a first step in assessing care needs and evaluating quality of care delivered, AAGP recommends that the VA conduct epidemiological research on psychiatric disorders and access to mental health services among veterans receiving care in these programs. Based on the findings from these studies, the VA should then define processes for delivery of quality mental health care and develop age-appropriate mental health services in these settings.

Psychiatric care of elderly long-term care patients is rendered more complex because of the frequent co-occurrence of medical illness, which usually requires treatment with multiple medications. Older long-term care patients commonly suffer from co-existing medical conditions such as diabetes, hypertension, heart disease, stroke, lung disease, osteoarthritis, or other conditions. For these patients, diagnosis and treatment of their medical illnesses is often complicated by psychiatric disorders. Conversely, the assessment and management of their psychiatric illness is more difficult because of concurrent medical conditions. Diagnosis may be confounded because of medical symptoms that mimic psychiatric disorders, or psychiatric symptoms that mimic medical illnesses. Disease-disease interactions, disease-drug interactions, and drug-drug interactions can challenge even the most experienced health care professionals. Thus, for older veterans with long-term care needs—whether institutionalized, or receiving long-term care services in non-institutional programs in the VA or the community—psychiatric treatment must be an integral component of their health care, must be informed by sufficient geriatric training, and must be well-coordinated with the medical, rehabilitative, and nursing care they receive for other medical conditions.

As veterans with mental illness are living longer, they are at increased risk for developing the illnesses and disabilities that are common in late-life. For example, the World War II

veteran with chronic schizophrenia, now grown old, may suffer from a stroke or debilitating arthritis. These chronic conditions may limit independent ambulation and overall mobility, and the resulting disability and frailty leads to a need for long-term care. While some veterans with strokes or arthritis may be able to remain in the community if provided with non-institutional long-term care services, those with severe chronic mental illness often have life-long deficits in independent living skills. Some of them have spent much of their early adulthood and middle-age living in institutional settings, and have never acquired the skills necessary to live in the community. Those veterans with chronic mental illness who develop cognitive impairment in late-life are even more disabled, and incapable of learning the skills that might enable them to adapt and accept services from non-institutional long term care programs. Many of them also have disruptive behaviors that have persisted into the later stages of life, and that cannot be adequately managed in non-institutional long-term care settings. This is because typical home-based primary care and adult day health care programs do not have sufficient access to age-appropriate mental health services. Thus, most non-institutional programs are designed to manage physical frailty and disability, but not mental disorders. Until access to geriatric mental health services is integrated in these programs, it will be difficult, if not impossible, for them to accommodate older adults with serious mental illnesses such as schizophrenia, or severe behavioral disturbances such as those associated with dementia.

While the VA does provide community residential care and psychiatric residential rehabilitation programs in some locations, these are limited in their ability to care for frail older adults with multiple chronic, debilitating medical conditions. To illustrate, many Viet Nam veterans suffer from post-traumatic stress disorder, and some have severe, disabling anxiety and behavioral disturbances that require psychiatric rehabilitation. But many of these baby-boomers have also begun to experience the complications of diabetes, and to develop heart disease and arthritis and other infirmities associated with later stages of life. Community residential care is primarily designed to deal with psychiatric and behavioral problems and the associated disability; but these programs are not equipped to take care of them when their medical problems become complex, or as they grow old and frail. For those without family supports, frailty may therefore eventually lead to a need for nursing home care.

It is important to note that, between the years 1990 and 2000, the number of veterans in the 45-54 year old age group who received mental health services from the VA more than tripled. However, the most rapid growth in demand during the last decade was among the oldest veterans. During that time, there was a four-fold increase in the number of veterans aged 75-84 who received VA mental health services. This substantial increase in utilization is even more striking when one considers that research has revealed an ongoing problem with under-diagnosis of mental disorders in older age groups. As the most rapid population growth is expected to continue among the oldest old veterans, the extent of physical frailty, combined with the high prevalence and complexity of interacting medical and psychiatric illnesses, is likely to increase the demand for nursing home care, even as non-institutional long-term care options are expanded.

In conclusion, the projected aging of the veteran population will require the VA to increase its capacity to provide long-term health care and to continue its efforts to expand non-institutional options while preserving and enlarging its network of nursing homes. Although the Veterans Millennium Health Care and Benefits Act (November 1999, P.L. 106-117) requires the VA to provide extended care services at 1998 levels, this will not be sufficient to meet the demands of the wave of baby boomer veterans who are about to enter old age. Congress should not only support the VA's commitment to non-institutional options, but must also ensure the continued availability of nursing homes for the oldest, most frail patients who cannot be maintained in home or community settings. Moreover, the current models of extended care are sorely deficient in the provision of age-appropriate mental health care. Quality of care for elderly veterans with long-term care needs will require substantial attention to the epidemiology of mental illness in this population, and the provision of geriatric mental health services that are integrated into both institutional and non-institutional programs.

Thank you for the opportunity to testify here today. On behalf of the American Association for Geriatric Psychiatry, we look forward to working with you to ensure that the long-term care needs of all veterans are met in the coming years. I will be happy to answer any questions.